VERMONT DEPARTMENT OF MENTAL HEALTH

CERTIFICATE OF APPROVAL APPLICATION/ PROPOSAL VSH FUTURES CRISIS STABILIZATION/ INPATIENT DIVERSION BEDS

COVER PAGE

Applicant:

HowardCenter

Project Title:

Expansion of The ASSIST Program

Principal Contract:

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PROPOSAL FOR INCREASED CRISIS BED CAPACITY HOWARDCENTER

I. Abstract

Our proposal is to expand and re-tool ASSIST, our crisis hospital diversion program that has been in existence since the early eighties. The primary elements of our proposal are 1) to increase from three beds to six beds; 2) to renovate our existing space to expand bed capacity and to maximize staffing resources through the co-location of our Mobile Crisis Team and medical staff; 3) increase number and type of staff to allow us to admit individuals who are in a more acute stage of their crisis; and 3) re-tool our therapeutic programming to better assist clients to return to their previous level of functioning, using cognitive-behavioral counseling techniques and behavioral analyses 4) incorporate peer support services by working with the Peer Leadership Program at Westview House. We believe that by expanding our current capacity we could make a significant reduction in the statewide utilization of psychiatric inpatient beds.

II. Proposal Overview and Program Description:

Since our inception, we have been serving people with serious mental illness as well as those who are less disabled but who have found themselves in the midst of a psychiatric crisis. As the state's largest volume Crisis Service, we have used ASSIST extensively to divert as well as shorten inpatient stays. In fiscal 2007 we had 352 separate admissions to ASSIST, for a total of 868 bed days. In addition, our Mobile Crisis Team admitted 278 individuals to inpatient units voluntarily, and another 128 involuntarily. Our Agency utilized 23% of the 13,240 bed days at Vermont State Hospital during this past fiscal year, for a total of 3,070 days. We believe that at least 10% and 15% of the voluntary admissions could have been diverted, and the VSH bed days reduced by the same percentage had we had additional resources at ASSIST to manage these clients.

We believe that with an increased bed capacity we could again offer hospital diversion services to all adults in our catchment area, regardless of whether they are currently part of the CRT cohort at our Agency, and would also be better able to provide services to clients from adjacent counties, such as Addison County.

Beginning in July 2007 we converted our double room at ASSIST to a single, based on feedback from our consumers and with the understanding it is more clinically appropriate to offer single rooms to clients in crisis. In addition budget cuts had reduced our staffing significantly, making it no longer feasible to provide adequate supervision for four beds. This proposal seeks to increase from our current four full time and three part time staff (6.4 FTE) to six full time and six part time staff (10.8 FTE), and to have two of the new full time positions be filled by nurses. We have observed the success of other agencies that have utilized this model and see its clinical advantages. We feel the addition of nurses would significantly enhance our ability to care for individuals in periods of acute decompensation. (See staffing schedule, Appendix A.). Finally, by increasing the

number of beds, we will effectively reduce the per bed cost by 14%, from the current \$610 a day to \$522 per bed.

Admission Criteria and Care Management:

All adults who are experiencing a psychiatric crisis would be eligible to be served by the ASSIST Program. (See Admission Criteria, Appendix B). The Program structure will remain as it currently is; that is, referrals will come primarily from two sources: case management staff (See Case Management Referral Form, Appendix C) and screeners on the Mobile Crisis Team who are generally evaluating potential clients in the Fletcher Allen Emergency Room. All potential admissions are reviewed by our attending psychiatrist or psychiatric resident currently on rotation to make sure that it is the appropriate level of care for that individual at that time. Also, being part of the Fletcher Allen inpatient staff as well, they have the ability to insure treatment continuity between FAHC and the ASSIST Program, especially in terms of step-down admissions.

Our appeal for prospective clients is the non-institutional feel of the program, its home-like atmosphere, and relatively small size and flexibility regarding clients' ability to continue activities in the community. There is the potential for a great deal of staff contact, which is consistently cited by clients as the most helpful aspect of the Program. The location and design will continue to allow clients easy access to the outdoors, negating any sense of being confined and controlled, and affording them greater mobility and freedom. They are able to choose their own food, and cook for themselves if they would like to, but also can get staff help if they need it. This helps them retain important skills and, again, maintain a sense of control of daily activities that is lost in an inpatient setting. In addition, we have recognized that many clients are nicotine dependent, and so provide an area where people can smoke, which is rarely an option in a hospital and makes ASSIST a more attractive alternative. It also gives us an opportunity to engage them in a smoking cessation Program of which HowardCenter is a leader in the State.

Our strength has historically been our ability to tailor treatment to the individual, and, as such, we feel confident that we will be able to serve an adult in an acute mental health crisis, regardless of whether they are CRT eligible or not. Any increase in our bed capacity would be welcomed by both the Fletcher Allen Emergency Department and the inpatient units. They are eager for us to increase capacity to further divert inpatient admissions, especially to include non-CRT clients, and to help use the program as a step down option that can shorten the stays of current patients on Shepardson 3 and 6. The step-down option was clearly cited in the Vermont Legislature's Consulting Group Report of August 21, 2007 on the Future of VSH and Systems of Care. "The need for high cost acute care beds can be lessened if sub-acute beds (also known as "step down beds") are available in a non-hospital setting."

Finally, we are poised and ready to revise and update our program brochure in an effort to reflect any changes and to make it more consumer friendly and appealing to referrals.

Our mechanisms of interface with other systems are well established. Twice daily we review cases with our Mobile crisis staff, our ASSIST staff, and our medical team, which is made up of our attending psychiatrist who is an Associate Professor of Psychiatry at Fletcher Allen Health Care, a rotating psychiatric resident, and medical students. At these times we do updates on progress towards goals, treatment recommendations, and utilization reviews. In addition, our supervisors attend weekly "Bed" meetings that have representation from the State Hospital, HC case management, medical, and residential teams to review progress for VSH patients and discuss discharge plans. We also use these meetings to alert staff to individuals who may be going into crisis, to coordinate care and to make referrals to longer term placements into other MH/SA programs when necessary. With increased staffing we would propose to have one staff attend weekly case management team meetings as well, to coordinate treatment and intervene with clients before they reach crisis levels.

Mobile Crisis staff have near daily contact with other inpatient units around the state, and have developed working relationships with admission coordinators. These relationships can be used to spread the word of increased capacity and inform referrals of the potential of using ASSIST as a step-down facility as well.

When all parties, including the client, identify that the goals stated upon admission have been met, we determine that the client is ready for discharge. Our policy is to notify other service providers if a client is returning to a group living situation, or to another community based provider. (See Discharge Criteria, Appendix D).

Clinical Program

- Daily medical oversight and daily access to a psychiatrist: Through our affiliation with Fletcher Allen Health Care we have a full time psychiatrist who oversees all work done at the ASSIST Program. He or his designee is available to meet with each client at ASSIST daily, to review progress and assess the effectiveness of medications. Our new plan features hiring two full time nurses so that we can better manage more difficult cases and attend to the medical needs of clients in a timely manner.
- Clinical and therapeutic programming designed to address psychiatric crises and assist clients to return to previous or improved levels of functioning: Basic CBT skills will be used by ASSIST staff to help clients understand the events that triggered the crisis episode. We propose to put all staff through a week long comprehensive training that includes: NAPPI, DBT basics, CBT basics, trauma informed service, mindfulness practice and behavioral analyses. Our chief psychologist, Dr. Anthony Quintiliani, will provide training in Evidence-Based Practices in these areas. We expect to rely heavily on technology from the Linehan model of DBT to perform Behavioral Analyses with clients that will allow them to review the crisis episode and identify alternative behaviors and coping strategies. Recently a number of HC staff were trained in EMDR, and they present an additional resource to the ASSIST Program. Medications will be supervised by staff with oversight from our nursing staff. Finally, any client who presents with co-occurring

- substance abuse issues will be asked to attend the ACT One/ Bridge daily Community Support Group.
- Peer services and support: Westview House, our psychosocial clubhouse program, currently has a Peer Leadership Program, through which consumers work in a variety of settings to provide support to other consumers. We propose to recruit from this cohort, as well as advertise in the Westview News, to engage those individuals who are interested in utilizing their Peer Leader skills at ASSIST. Westview House has Peer Leadership meetings twice monthly, which also function as a group supervision venue. This group has been approached, and they are enthusiastic about the prospect of "giving back" to ASSIST. During these meetings consumers can bring up any problematic or challenging situations that they have encountered, and receive feedback and guidance. Participants are paid an hourly wage through the HC payroll system, and receive the same trainings as any other employee, which include First Aid, Universal Precautions and Respect. The group also suggested that they receive additional training to for their work at ASSIST. specifically NAPPI. We propose to add the option of Peer Support Services for clients at ASSIST. Working in teams, preferably with each gender represented, Peer Leaders would be able to spend one to one time with clients while they are at ASSIST, helping them to re-establish supports in the community and/or support the delivery of skill based recovery curriculums. The Peer Leader group also suggested that they could do some phone and/or in person follow-up once the person returns home, to reinforce the gains made and insure ongoing stabilization. This initiative would also expand and actualize our trauma-informed care by capitalizing on the prior life experiences of the Peer Leaders themselves.
- Adequate Staffing: We propose to increase from our current 6.4 FTE direct services staff to 10.8 FTE direct service staff. Most significantly, we propose that two of the full time positions be nurses. Our expectation is that by adding a nursing presence we could have better ongoing supervision of complex medications regimens and be able to attend to other medical concerns as they arise. The nursing staff would also be responsible for triaging admissions and discharges, and could be proactive by calling inpatient facilities on a daily basis to see if anyone is able to utilize ASSIST as a step-down option. In addition, having double coverage would allow us to spend significantly more time with clients, and accompany them out in the community to further re-integration after ASSIST. (See attached Current and Proposed Staffing schedules, Appendix A).

Staffing Patterns

Current ASSIST staff would be used, and we would increase our recruitment efforts. The Agency has recently contracted with JobsInVermont to expand our exposure to possible candidates. (See above for more specifics, and Current and Proposed Staffing Attachment, Appendix A).

III. Proposed location:

We propose to extend the current corridor on the north side of 300 Flynn Avenue to increase our square footage from 1,200 square feet to approximately 2,400 square feet, with the goal of adding three beds and co-locating the Crisis Services medical, supervisory and Mobile Crisis staff within this addition. Please refer to the letter from our Director of Facilities, Appendix E, and a schematic drawing of the existing space and proposed addition, Appendix F.

IV. System Need, Local Support. Strategic Planning and Outcomes

Our 2006-7 Report of Local System of Care clearly identified the retention of hospital diversion beds as a priority. Last year, when we faced some difficult financial decisions that had ramifications for the future of the ASSIST Program, members of our Mental Health standing committees (known as CAN, the Consumer Advisory Network), and the Agency Board of Directors, expressed very strong feelings about the value of ASSIST and the importance of developing strategies to keep and expand the services as a treatment option. On August 29, 2007 we presented the current proposal to the CAN group and received very positive support as well as excellent suggestions of ideas for future services and clinical interventions. We propose to continue to use the CAN meetings as a vehicle through which to provide ongoing consumer input for future strategic planning of the direction and progress of the project. The "crisis bed proposal" will be a regular agenda item. In addition, all policies and policy changes are reviewed by our standing committees and signed off by our Board of Directors.

For the past five years we have carefully tracked outcomes measures for the ASSIST Program. As a CARF accredited program, we track outcomes measures in the areas of efficiency, effectiveness, access, consumer satisfaction and follow-up (See Year End Summary, Appendix G). The outcome of particular interest to this project is that of our rate of hospital diversion. For fiscal 2006-2007, an average of 94% of the clients we served was able to return to their baseline, pre-crisis community setting. In addition, each admission is tracked in terms of the primary reason for a crisis bed. That is, we determine if the primary referral reason is as a hospital diversion, a respite, or a step-down from a higher level of care. In fiscal 2007, 49% of all bed days used were clearly in lieu of the individual being in the hospital, for a total of 426 bed days. With an additional three beds, estimating an average utilization of 80% of capacity, we would conservatively anticipate that at the same rate of diversion the impact on inpatient bed days could be reduced by at least 429 bed days yearly.

V. Organizational Structure

(See Appendix H)

HowardCenter is a private, nonprofit organization founded in 1873 as an agency serving the children of the destitute. Today it provides mental health, developmental disabilities, substance abuse, and child and family treatment services to more than 14,000 individuals

each year. The mission of HowardCenter is to improve the well being of children, adults, families, and communities.

Our core values and beliefs are:

- We believe in the inherent worth and dignity of every individual.
- We believe in the human capacity for growth and development.
- We believe that health and well being come through positive relationships with others, healthy connections with family and community, contributing to others, and caring and taking responsibility for oneself.

Our agency recently adopted a unified name. We are pleased that our agency is now called **HowardCenter**. Thirteen years ago the Baird Center, Champlain Drug and Alcohol Services, and The Howard Center for Human Services merged. Through the years, many community members thought of us as separate agencies. Our agency's Board and staff leadership believe strongly that to increase understanding of the work we do, we must now be one unified agency.

This change is about more than a revised name. It is also about simplifying to make our organization more accessible to those seeking services and easier for the community to understand. HowardCenter will continue to provide developmental; mental health; substance abuse; and child, youth, and family services. Our major service areas are now known as Child, Youth and Family Services (formerly Baird), Developmental Services (formerly Howard Community Services), and Mental Health and Substance Abuse Services (formerly Adult Behavioral health Services/Champlain Drug and Alcohol Services). In addition to our unified name, we now have a common telephone exchange – 488 – for all of our programs. We are continually working to make our programs more accessible in order to achieve our goal of "No Wrong Door" to services.

Governance

HowardCenter is governed by a volunteer Board of Trustees, which currently has 19 members. Trustees represent a broad spectrum of the community. Over 50% of the members are either consumers of services or family members of individuals who would be eligible to receive services from the agency. In addition to the Board, there are four Board Standing Committees, one for each major service area. Todd M. Centybear serves as Executive Director of HowardCenter. He has been with the agency for more than 30 years.

Relationships with Other Non-Profit Organizations

The following listing illustrates the breadth of HowardCenter's connections with other non-profit organizations.

We run programs with other organizations as our partners.

- Crisis Services of Chittenden County 24-hour crisis program is run in partnership with Fletcher Allen Hospital, Vermont's only teaching hospital.
- Centerpoint intensive outpatient substance abuse program for adolescents is run in partnership with Northeastern Family Institute and Matrix (a for-profit corporation).
- Homeless Health Project to serve individuals with mental illness who are homeless we partner with the Community Health Center, Committee on Temporary Shelter, and the Visiting Nurse Association.
- JOBS Program introduces youth receiving HowardCenter services to employment opportunities. Our partner in this program is Spectrum Youth and Family Services.
- Eldercare Initiative we work with Fletcher Allen Health Care to provide mental health services in area nursing homes.
- Substance Abuse Services of Central Vermont we partner with two other agencies to provide drug and alcohol services in Washington County.
- Northern Lights a residential alternative to incarceration for women from Chittenden County is a collaboration between HowardCenter, the Vermont Children's Aid Society, the Department of Corrections, Mercy Connections and the Burlington Housing Authority.
- Collaborative Solutions Corporation we partner with Washington County Mental Health and the Clara Martin Center to offer intensive residential supports to clients being discharged from the Vermont State Hospital.

We rely on community organizations to serve our clients directly.

We believe that in order to be successful in integrating our clients into the life of the community we must rely on as many "natural supports" as possible and not create programs that segregate our clients from the rest of the community. Some of the organizations that we work with very cooperatively include YMCA, Very Special Arts Vermont, GRACE Arts Project, Vermont Adaptive Ski and Sports, and Fletcher Free Library.

Housing connections meet a critical need.

Safe, secure, and affordable housing is a critical need for the individuals we serve. We work closely with local housing providers who have the expertise in developing housing. These organizations include Lake Champlain Housing Development Corporation, Habitat for Humanity, Burlington Community Land Trust, Cathedral Square Corporation, King Street Area Development Corporation, Committee on Temporary Shelter, YWCA, and Burlington Emergency Shelter.

Other non-profits that we work with or contract with on a regular basis.

These include Women Helping Battered Women, Easter Seals, Milton Family Center, Child Protection Network, Home Base, Champlain Vocational Services, Maple Leaf Farm, Vermont CARES, Alcoholics and Narcotics Anonymous, and Planned Parenthood.

Connections to organizations that are not non-profits.

The Howard Center has many other connections beyond those listed above.

- Police Departments and Corrections We have very good and active relationships with local police departments through ACT I, Crisis Services of Chittenden County, and the Street Outreach Team. Employment Programs Through Project Hire and Westview Employment Services we place and support our clients in paid employment with over 40 area employers.
- State Agencies We receive funding from the following through grants, contracts and/or reimbursement: DAIL, Mental Health Department, Department of Corrections, Vocational Rehabilitation, Department of Education, Office of Alcohol and Drug Abuse Programs, Department of Health, Department for Children and Families, and the Agency of Human Services.

Policy on ongoing consumer involvement in governing the entity:

POLICY ON INPUT FROM THOSE SERVED

It is the belief of this organization that services provided should be consumer focused. The participation of clients in program evaluation, planning, and quality assurance is seen as integral to carrying out the mission of the agency in enhancing the lives of children and families and persons with mental illness, developmental disabilities, and substance abuse. It is therefore the policy of The Howard Center for Human Services to solicit input from those served.

- 1. Each program within the organization will establish a system for obtaining client input that reflects the unique characteristics of the program.
- 2. This system will be grounded in values upon which that program is predicated.
- 3. The means of evaluation will be operationalized in a manner that is appropriate to the needs of the population served. Specifically, language and format will be understandable to clients and presented in such a way as to elicit honest feedback and enhance the reliability of responses.
- 4. Consumer input will be integrated annually into the system of care planning process as program and agency goals are established.
- 5. Consumer input into program planning and evaluation will occur on a less formal, ongoing basis based on the needs of individuals programs.
- 6. Documentation of the results of consumer input will appear in the annual system of care plans.
- 7. All consumers are involved in the planning of their own treatment.
- 8. Not fewer than 51% of the Board of Trustees of the agency shall be disclosed "consumers" or "family members" as the Agency of Human Services defines those

terms. Consumers also are a majority on the agency's Standing Committees for each of the four major service areas.

Specific to this project, we have already presented the proposal to our CAN Group, and have enlisted both their support and an ongoing commitment for further involvement and oversight. The CAN Group is made up of staff, family members, and consumers, many of whom have used the ASSIST program themselves, and so have first hand knowledge and insights about future directions

VI. Projected Costs and Financial Feasibility:

Prior to submitting this proposal we discussed the feasibility of creating a free-standing structure that could house all of our Crisis Services staff and programs, but soon realized that the proximity to case management and medical staff, as well as other support services, were critical to the smooth flow of referrals and discharges and helped us to ensure continuity of care. Further, in our plan we hope to be able to draw upon current resources, such as our Mobile Team staff, to enhance our staffing and hence, the success of the project. As noted previously, with the addition of three beds our per bed cost actually goes down from the current \$610 per bed to \$522 per bed, making our program more cost effective. Please see our attached Budget sheet for details.

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		FY '08	Based on "Expansion Cost"		
	Existing	Expansion Cost	New Budget	FY '09	FY '10
DMH GRANT	\$ -	\$ 381,772.18	\$ 381,772.18	\$ 393,225.35	\$ 405,022.11
OTHER REVENUE (IDENTIFY):					
SOURCE 1: CRT Case Rate	\$ 534,390.73	\$ -	\$ 534,390.73	\$ -	\$ -
• SOURCE 2	\$ -	\$ -	\$ -	\$ -	\$ -
• SOURCE 3	\$ -	\$ -	\$ -	\$ -	\$ -
Total Revenue:	\$ 534,390.73	\$ 381,772.18	\$ 916,162.91	\$ 393,225.35	\$ 405,022.11

EXPENSES

STAFF	HRS/WK				٩N	NUAL COST			
Clinical Staff	165.00	\$	201,281.80	\$ -	\$	201,281.80	\$ -	\$	_
Substitutes	41.36	\$	27,136.71	\$ -	\$		\$ -	\$	_
Program Management	35.08	\$	60,866.33	\$ -	\$		\$ -	\$	-
Administrative Staff	5.63	\$	3,356.44	\$ -	\$	3,356.44	\$ -	\$	-
• Increased responsibility for Lead	Clinical	\$	-	\$ 5,000.00	\$	5,000.00	\$ 5,150.00	\$	5,304.50
Nursing (2 FTE)	75.00	\$	-	\$ 85,800.00	\$	85,800.00	\$ 88,374.00	\$	91,025.22
Nursing Sub		\$	-	\$ 13,200.00	\$	13,200.00	\$ 13,596.00	\$	14,003.88
Additional Clinical (2.4 FTE)	90.00	\$	-	\$ 65,520.00	\$	65,520.00	\$ 67,485.60	\$	69,510.17
Additional Clinical Subs		\$	-	\$ 10,080.00	\$	10,080.00	\$ 10,382.40	\$	10,693.87
Subtotal of Staff		\$	292,641.28	\$ 179,600.00	\$	472,241.28	\$ 184,988.00	\$	190,537.64
Fringe - Benefited Staff: 35.44%		\$	95,106.71	\$ 55,399.81	\$	150,506.52	\$ 57,061.80	\$	58,773.65
Fringe - Non-Benefited Staff: 10.76	<u>8%</u>	\$	2,613.45	\$ 2,504.93	\$	5,118.38	\$ 2,580.08	\$	2,657.48
Total Staff Cost		\$	390,361.44	\$ 237,504.74	\$	627,866.18	\$ 244,629.88	\$	251,968.77
	****	,						•	
ON-CALL STAFF	HRS/WK								
		\$	-	\$ _	\$	-	\$ -	\$	-
•		\$	-	\$ _	\$	_	\$ -	\$	-
•		\$	_	\$ -	\$	-	\$ _	\$	_
Total On-Call Staff		\$	-	\$ -	\$	-	\$ -	\$	-
OPERATING EXPENSES	Per Mth								
Building Allocation	\$ 2,087.28	\$	25,047.39	\$ _	\$	25,047.39	\$ -	\$	_
Depreciation - Buildings	\$ 3,583.33	\$	-	\$ 43,000.00	\$	43,000.00	\$ 44,290.00	\$	45,618.70
Mortgage Interest	\$ 2,076.63	\$	_	\$ 24,919.52	\$	24,919.52	\$ 25,667.12	\$	26,437.13
Phone	\$ 105.61	\$	617.33	\$ 650.00	\$	1,267.33	\$ 669.50	\$	689.59
Medical Center Contracted	\$ 3,164.92	\$	37,979.00	\$ -	\$	37,979.00	\$ -	\$	-
Food	\$ 1,163.62	\$	6,963.42	\$ 7,000.00	\$	13,963.42	\$ 7,210.00	\$	7,426.30
Cleaning/Trash/Laundry	\$ 738.09	\$	857.13	\$ 8,000.00	\$	8,857.13	\$ 8,240.00	\$	8,487.20
Supplies (Cleaning/Bedding/etc.)	\$ 718.59	\$	3,923.11	\$ 4,700.00	\$	8,623.11	\$ 4,841.00	\$	4,986.23
Staff Training	\$ 168.33	\$	20.00	\$ 2,000.00	\$	2,020.00	\$ 2,060.00	\$	2,121.80
Agency Meetings & Publications	\$ 49.45	\$	43.35	\$ 550.00	\$	593.35	\$ 566.50	\$	583.50
Mileage/Transportation	\$ 489.71	\$	3,126.53	\$ 2,750.00	\$	5,876.53	\$ 2,832.50	\$	2,917.48
Other	\$ 1,160.42	\$	5,825.02	\$ 8,100.00	\$	13,925.02	\$ 8,343.00	\$	8,593.29
Total Operating Expenses	\$ 15,505.98	\$	84,402.28	\$ 101,669.52	\$	186,071.80	\$ 104,719.62	\$	107,861.20
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Total Direct Expenses	\$ 474,763.72	\$ 339,174.26	\$ 813,937.98	\$ 349,349.49	\$ 359,829.98
Division Administration 2.84%	\$ 13,472.59	\$ 9,624.91	\$ 23,097.50	\$ 9,913.66	\$ 10,211.07
Agency Administration 9.72%	\$ 46,154.42	\$ 32,973.01	\$ 79,127.43	\$ 33,962.20	\$ 34,981.07
Total Expenses	\$ 534,390.73	\$ 381,772.18	\$ 916,162.91	\$ 393,225.35	\$ 405,022.11

Appendix A

Current ASSIST Schedule:

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
FT	8 - 5	8 - 5	8 – 5	3 - 12			
FT				8 – 5	8 – 5	8 - 5	8 - 5
FT	A-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	12 –	12 –	12 –	12 –	12 –	
		7:30	7:30	7:30	7:30	7:30	
PT	3 – 12	3 - 12	3 - 12				
PT					3 – 12	3 - 12	3 - 12
PT				11pm –	11pm –	11pm –	
				9am	9am	9am	
FT	11:30 -	11:30 -	11:30 -				11:30 -
	8:30am	8:30am	8:30am				8:30am

Proposed ASSIST Schedule:

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
FT/RN	8 – 5	8 – 5	8-5	8-5			
FT	8 – 5	8 – 5	8 – 5	8 - 5			
PT					8 – 5	8 – 5	8 – 5
PT					8 – 5	8 – 5	8 – 5
PT	3 – 12	3 – 12	3 – 12				W W W
PT	3 – 12	3 – 12	3 – 12				****
FT/RN				3 - 12	3 – 12	3 – 12	3 – 12
FT				3 - 12	3 – 12	3 – 12	3 - 12
FT	11:30 – 8:30am	11:30 – 8:30am	11:30 – 8:30am	11:30 – 8:30am			
PT					11 – 9	11 – 9	11 - 9

Appendix B

HowardCenter Crisis Services of Chittenden County ASSIST Program - Admission Criteria

ASSIST is a psychiatric emergency hospital diversion program of the Crisis Services of Chittenden County, part of HowardCenter. Our goal is to provide respite and support to individuals who are experiencing an acute emotional crisis. We have the capacity to house up to four individuals, and use the following criteria in reviewing requests for admission:

- 1. Individuals need the structure and safety of a program staffed twenty-four hours a day.
- 2. May be seeking inpatient hospitalization but may be clinically appropriate for a less restrictive setting.
- 3. Are undergoing a medication change, beginning or resumption and are in need of monitoring
- 4. May need structure and support to facilitate the transition from an extended inpatient stay to return to the community (step-down).
- 5. Are willing to stay voluntarily
- 6. Are willing to follow an individualized treatment plan.
- 7. Have the ability to perform basic self-care activities and are ambulatory.

While the average length of stay is 3-5 days, individuals may need longer or shorter stays, depending on their unique circumstances and their response to treatment. If the client has a case manager or therapist here at HC, we request that the treating professional fill out an initial referral form, indicating goals for the stay. We also ask that s/he makes contact with the client each day of their ASSIST stay. All potential clients are interviewed prior to admission. During normal work hours admissions of case managed clients can done directly by their case manager in consultation with the ASSIST staff. If a client is not known to us, they would be asked to be seen by a member of the Mobile Crisis Team. All admissions are reviewed by our attending psychiatrist or psychiatric resident on rotation. After hours, all admissions go through the FAHC ER and are screened by the Mobile Crisis Team.

There are some individuals who we are not able to effectively treat in our program. The following are reasons why we would not accept a client for admission:

- 1. Individuals whose primary diagnosis is substance abuse and who are not currently experiencing any psychiatric symptomatology.
- 2. Those whose primary issue is a lack of housing.
- 3. Individuals who have significant medical conditions or needs that extend beyond our capacity to treat.
- 4. Unwilling to agree to basic program guidelines, and expectations (e.g., no smoking indoors, etc.)
- 5. Are extremely agitated, violent, hypersexual, etc.
- 6. Whose presence would jeopardize the safety and/or the well-being of the clients already on the Unit. This includes presenting a need for a high level of care when there is already one or more acute clients on the Unit.

Appendix C

Crisis Services of Chittenden County ASSIST PROGRAM Case Management Referral Form

Date:		
Client Name:	Client #:	
Case Manager:	Tel #:	
Reason for referral:		
Waiting to go into the hospitalRespite/ Time outHospital DiversionStep-down		
Initial goals for the stay:		
1)		
2)		
3)		
Suggested length of stay:		
Howa will we know when goals have been	en met?	
Follow-up plan:		

Appendix D

HowardCenter Crisis Services of Chittenden County The ASSIST Program Discharge Criteria

ASSIST is a psychiatric emergency respite and support program of the Crisis Services of Chittenden County, part of HowardCenter. Our goal is to provide respite and support to individuals who are experiencing an acute emotional crisis. Lengths of stay average a few days, but can be longer or shorter depending on the individual's circumstances and response to treatment. The following are some of the criteria we use when assessing whether a person is ready for discharge:

- 1. No longer expressing suicidal or homicidal ideation.
- 2. If they are chronically suicidal, they have a safety plan and/or no immediate means to self-harm.
- 3. If they have an affective disorder, there has been a decrease in neurovegetative signs, such as improved sleep and appetite.
- 4. If they have a psychotic disorder, there has been a decrease in symptoms such as delusions, paranoia, auditory or visual hallucinations.
- 5. They are able to communicate with staff about their needs, wants, and/or future plans.
- 6. They have a viable housing plan to which they have, however reluctantly, agreed. This may be their own apartment, a group home, or a shelter, to name a few possibilities.
- 7. They are medically stable.

There are situations in which we recognize that a client appears stable at ASSIST, but may be at risk of decompensating upon returning to the community. Our policy is to proceed with the discharge, but to maintain a low threshold for re-admission.

208 FLYNN AVENUE / SUITE 3J / BURLINGTON, VT 05401

T: 802.488.6900 / F: 802.488.6901

WWW.HOWARDCENTER.ORG

September 6, 2007

HowardCenter

Vermont State Hospital Futures Project Vermont Department of Mental Health

To Whom It May Concern:

I am writing to describe the proposed ASSIST expansion project for HowardCenter. We currently have 1,200 square feet of space used for this program and envision almost doubling the space with an addition. We would have to work with an architect and engineer to develop the plans for a renovation of this size and to assist us with the permitting process with Burlington and the State of Vermont.

We feel that our current space is fairly compliant with ADA even though it is an older building, and any new construction would comply with current ADA regulations. The architect would be instrumental in determining this.

I have included a floor plan that shows the current ASSIST space and the area that we hope would be used for an addition. Of course, this could change once an architect and engineer is brought on board as they may have better ideas on how to best approach this.

If I can be of any further assistance, please don't hesitate to contact me. I can be reached at 802-488-6970 or edv@howardcenter.org.

Sincerely,

Edward A. Vizvarie, REH, CMM

Director of Facilities

Enclosure

DET = NEW Space

APPENDIX G

CRISIS SERVICES OF CHITTENDEN COUNTY YEAR END SUMMARY 2006-2007

ASSIST PROGRAM

OUTCOME DATA:

The following goals were targeted for 2006-2007:

Effectiveness:

1. 85% of all clients will discharge to a less restrictive level of care and avoid use of in-patient treatment.

Outcome: An average of 94% of all clients who used the ASSIST Program was discharged to a less restrictive level of care. This continues to be well above our target goal.

Efficiency:

1. We will operate at an average monthly occupancy rate of 75%.

Outcome: Our average monthly occupancy rate for the year was 60%, below our target goal. At the beginning of the new fiscal year, we will be reducing the number of beds from four to three based on this information.

Access:

1. 60% of all admissions will be for Community Rehabilitation and Treatment (CRT) clients.

Outcome: 67% of all admissions to ASSIST were for CRT clients during the year, above our target goal.

Consumer Satisfaction:

1. 75%-80% of clients will report basic satisfaction with services that they received while at ASSIST.

Outcome: An average of 99% clients surveyed reported basis satisfaction with services.

Follow-up:

1. 75% of clients interviewed by phone in the month following their discharge will report that they feel better than when they received services from ASSIST.

Outcome: Ninety-three percent of clients surveyed reported that they felt they were doing better than when at ASSIST. We were able to contact 35% of clients served. (120 out of a total of 80 discharges during the year.)

HowardCenter

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Katherine Connolly, President

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				Quality/Risk *	Manager Gail Rosenberg	Manager Gail Rose
		Sandra Steingard, MD	Manager Cheryl Couture	Lorraine Jenne Human Resources	oment Parin	& Development Mary McKearin
		Agency Medical Director	Administrative Services	Director of Operations	Director of Agency Planning	Director o
			Executive Director Todd Centybear	Execut Todd	٠	

	Facilities Ed Vizvarie	Fiscal Manager - DS Bill Pence Fiscal Manager - CYF Sandy Matthews	Health Information David Kronoff Fiscal Manager - MHSA Jeff Dudley	Information Systems Russell Stratton	Controller	Charles Stringer, Director
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Administrative Services Deb Sullivan Mitch Barron is supervised by Catherine Simonson.	Baird School - Laura Smith CenterPoint - Mitch Barron*	First Call - Robin Pesci IFBS - Linda Clark Residential - Laura Brown Park Street - Shelly	Family & Community Based Services - Beth Goss JOBS - Gina D'Ambrosio Family Support Services - Aimee Upchurch	Assistant Director Robin Yandell	Quality Assurance Laura Pearce	Child, Youth & Catherine Simonson,
Administrative Services Manager Deb Sullivan ervised by Catherine Simonson.	Garvin School - Lisa Bilowith Consultation & Training - Debbie Mintz	Outpatient - Beth Holden Early Childhood - Gail Rafferty INCLUSION - Kristle Reed Autism Spectrum Program - Anno Beredico	School Services - Coleen Lillie Pine Forest Children's Community - Wendy Lachapelle Community Friends - Kristen Hayden-West	Assistant Director Betsy Cain		Director
Administrative Services Manager Dottle Corrigan	Pascal Cheng Financial & Administrative Support Bill Pence	Clinical Case Management Brian Gilbar Communication Services Coordinator	Mary Buttitta Services Coordination Tracy Schneider Project Hire Karen Hussey	Adult Services Sima Breiterman Personal Support Advocates		<u>Developmental Services</u> Marie Zura, Director
Family Services Advocate Chris Pepin Revised 8-28-2007	Dawn Bombard Human Resources/ Residential Lynette Lones	Family Support Advocates Jen Mitchell Flexible Family Funding/ Respite	Intervention Rich Carpenter Children and Family Services Cathie Buscaglia	Clinical Services Director Stan Baker Onion River and Crisis	Medical Director Paul Cotton, MD	tal Services